Department of Public Health
Division of Health Care Facility Licensure & Certification
99 Chauncy Street, 11th Floor,
Boston, MA 02111-1212

I, _____, hereby certify to the Department of Public
(your name)

Health, Division of Health Care Quality that I am entitled to receive confidential

information regarding _____, because:
(name of patient or resident)

(Please check the appropriate box. Where applicable, please attach a copy of documents demonstrating your legal status.)

- o I am the parent of a child under 18 years of age who is the patient or resident named in the record.
- o I am the court appointed legal guardian of the patient or resident named in the record under a current decree of guardianship.
- o I am the activated health Care Proxy of the patient or resident named in the record investigation.
- o I am the administrator or executor of the estate of the patient or resident named in the record.

Signature: _____ Date: _____

OR

- o I have the written permission of the patient or resident named in the record.

I, _____, give my permission to the Department
(name of patient or resident)

of Public Health to share confidential information contained in the Department's

records with _____
(name of person to receive a copy of the report)

Signature of Patient/Resident: _____ Date: _____